Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: CHRONIC PAIN RECOVERY CENTER 25810 OAK RIDGE DRIVE THE WOODLANDS TX 77380	MFDR Tracking #: M4-11-0726-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: SEABRIGHT INSURANCE CO REP BOX: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "The Requestor expresses its general disdain for the manner in which its claims have been processed. The Requestor maintains that it did use valid procedural coding inasmuch as it used procedural coding that is prescribed the the administrative rules of the Texas Department of Insurance, Division of Workers' Compensation. Specifically, 29 TEX. ADMIN. CODE §134.204(h)(5) states that: "For billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP' for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." 1. the Requestor utilized "unlisted physical medicine" code CPT 97799; 2. The Requestor utilized "CP" in the block supplied for modifier one; 3. The Requestor adequately represented its CARF Accreditation [Exhibit 1] status by utilizing "CA" in the block supplied for modifier two, and 4. The Requestor assured that "the number of hours [were] indicated in the units column on the bill. Due to the grossly inaccurate bill processing methodology utilized by the Carrier, the Requestor has no choice but to assume that the rationale given is merely a flippant excuse for some other motivating factor. The Requestor thus asserts that this Carrier has violated Labor Code TEX. LAB. Code §415.002(A)(13 in that it "misrepresent[ed] the reason for not paying benefits, or terminating or reducing the payment of benefits." The July 16, 2010 Request for Reconsideration was submitted via USPS Priority Mail Delivery Confirmation Number 0308 2040 0001 6091 5771 which – as noted above – was arrived at P.O. Box 67840, Phoenix Arizona 85082 on the date of July 22, 2010 [Exhibit 7] Three months have elapsed and – despite the fact that its receipt is demonstrable – the Carrier never responded to the Request for Reconsideration. Given the above, the Requestor asserts that the Carrier is in violation of 28 TEX. ADMIN. CODE §133.250(f) inasmuch as it failed to "take final action on a reconsideration request within 21 days of receiving the request for reconsideration." For these causes, the Requestor asks that Medical Fee Dispute Resolution issue a Findings and Decision that the Requestor is entitled to reimbursement for the services discussed herein, as well as all fees, interest and any other relief to which the Requestor may be justly entitled. The Requestor further asks that Medical Fee Dispute Resolution make an appropriate legal and compliance referral regarding the administrative violations outlined above."

Principal Documentation:

1. DWC060
2. Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $8,312.50

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "This medical dispute concerns reimbursement for a chronic pain management program the claimant participated in between October 26, 2009 and November 5, 2009. The carrier submits that this medical dispute should be dismissed with respect to dates of service October 26, 2009 through October 30, 2009. Medical dispute resolution must be sought within one year of the date the services were rendered, and in the present case, the date stamp on the DWC-60 reflects that medical dispute resolution was not sought until November 1, 2010. Consequently, this request for medical dispute resolution was not filed timely with respect to the dates of service October 26, 2009 through October 30, 2009. With respect to the dates of service November 2, 2009 through November 5, 2009, the carrier will re-audit these medical bills, and tender any reimbursement deemed necessary to the provider."

1. DWC060

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/26/2009 – 10/30/2009	111-002, NET-P, 850-020, ST-P	CPT Code 97799 CPCA – 8 units	$4,312.50	$0.00
11/02/2009, 11/03/2009, 11/04/2009, 11/05/2009	111-002, NET-P, 850-020, ST-P	CPT Code 97799 CPCA – 8 units/day	$4,000.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided between10/26/2009 through 11/05/2009.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 12/24/2009

   - 111-002 – Coventry Contract Status Indication 02 – Non-contracted provider
   - NET-P – Network Pricing
   - 850-020 – Please provide a valid CPT, HCPCS, NDC number and or quantity of drugs for further consideration of reimbursement.
   - ST-P – State/Province Pricing

Issues

1. Did the requestor submit the disputed dates of service timely and in accordance with 28 Tex. Admin. Code §133.307?
2. Was the requestor reimbursed for dates of service 11/02/2009 through 11/05/2009?

Findings

1. The Respondents position statement indicates that dates of service 10/26/2009 through 10/30/2009 were not filed timely under 28 Tex. Admin. Code §133.307. Review of Commissioner's Bulletin #B-0012-09 dated March 16, 2009 shows that the Hurricane Ike Proclamation was not extended beyond March 6, 2009; therefore, dates of service 10/26/2009 through 10/30/2009 were not submitted timely and not eligible for review under 28 Tex. Admin Code Section §133.307.

2. The Requestor was contacted in regards to dates of service 11/02/2009, 11/03/2009, 11/04/2009 and 11/05/2009. A facsimile transmission sheet was sent on 02/02/2011 withdrawing these dates of service as they have been paid.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

PART VI: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is NOT entitled to reimbursement for the services involved in this dispute.

		February 9, 2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.